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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Yemen

The Executive Director recommends that the Executive Board approve the country programme of Yemen for the period 1994 to 1998 in the amount of $12,500,000 from general resources, subject to the availability of funds, and $12,000,000 in supplementary funds, subject to availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. The unification of the People's Democratic Republic of Yemen and the Yemen Arab Republic in May 1990 established the most populous country on the Arabian peninsula, with the total population estimated at 11.6 million, comprising 9.3 million in the north and 2.3 million in the south. With the influx of some 800,000 returnees as a result of the Gulf crisis of 1990-1991, the population of Yemen grew to approximately 12.1 million. It is predominantly rural, with only 30 per cent living in urban areas. However, urbanization has been proceeding at a rate of almost 10 per cent per annum. Current trends in migration indicate that by the year 2000, 38 per cent of the population will reside in urban areas.

2. The high annual population growth rate, estimated at 3.4 per cent in 1991, reflects a combination of high fertility (7.3) and declining mortality, which has begun to erode many of the social and economic gains made over the past decade. At the current rate of growth, the population will reach over 22 million by the year 2010.

3. The infant mortality rate (IMR) in 1991 was estimated at 110 per 1,000 live births. This represents a 38 per cent decline over the last two decades. Disparity in IMR among governorates is significant and ranges from 171 in Jawf to 95 in Aden and 100 in Abyan and Taiz. The under-five mortality rate (U5MR) has also declined, from 293 to 180 per 1,000 live births in 1991. Despite this major improvement, the situation of children remains precarious.

4. With the highest IMR and U5MR in the Middle East, if current mortality trends continue, approximately 1 million infants and young children will die in Yemen during the 1990s. Almost two thirds of all child deaths occur due to a combination of malnutrition and infection in the first 12 months.

5. Diarrhoea and associated dehydration are recognized as the leading cause of infant and child mortality, responsible for almost 30 per cent of child deaths. The high mortality rate associated with diarrhoea is due primarily to a lack of family knowledge of, or access to, oral rehydration therapy (ORT) and the continued reliance on antibiotics and other marginally useful or ineffective drugs. Reducing the amount of food provided to children with diarrhoea is a common problem throughout Yemen, whereas the restriction of fluids is less widespread. While mothers recognize diarrhoea as a serious health problem, fewer than 50 per cent are aware of the benefits of oral rehydration salts (ORS). Although nationwide statistics are unavailable, regional data suggest that acute respiratory infections (ARI) are the second leading cause of death among children.

6. Vaccine-preventable diseases are also major causes of mortality among children in Yemen. Although the prevalence of these diseases has been difficult to quantify due to the absence of a national disease surveillance system, studies confirm that deaths from measles, diphtheria and poliomyelitis contribute significantly to the high child mortality and morbidity rates. Major progress has been achieved during the last four years in increasing the number of children protected by immunization. From less than 10 per cent coverage in 1987, the country achieved the goal of universal child immunization (UCI) in 1990 in all antigens except measles. During 1991 and 1992, however,

immunization coverage rates decreased substantially, due mainly to the deterioration of the economy following the Gulf crisis.

7. Widespread malnutrition and undernutrition among children is an important contributing factor to mortality and morbidity in Yemen. The national average for low-birth-weight babies is estimated at 19 per cent, with figures ranging between 7 and 35 per cent. A 1979 national nutritional survey estimated malnutrition at 67 per cent which has shown little improvement since then. Community-based studies indicate that 25 to 50 per cent of children below 3 years of age are malnourished to some degree, which is indicative of poor infant feeding practices and a decline in breast-feeding. Furthermore, local studies suggest that diarrhoea-related morbidity is highest among the 7- to 24-month age-group and that rural children have, on average, five episodes of diarrhoea per year.

8. In addition to protein-energy malnutrition, community studies confirm that micronutrient deficiencies are common among children. A 1992 survey conducted by the Government, UNICEF and Helen Keller International in the Tihama region reported levels of xerophthalmia in children three times the acceptable level, as determined by the World Health Organization (WHO). The survey also indicated a high prevalence of iodine deficiency among children.

9. The maternal mortality rate (MMR) in Yemen is reported to be extremely high, ranging from 300 to 1,000 per 100,000 live births. This helps to explain why, unlike in most other countries, life expectancy for females in Yemen is lower than for males. It is estimated that 62 per cent of maternal deaths are due directly to obstetric causes. Obstetric facilities in most hospitals and health centres are either unavailable or very limited. Most women with high-risk pregnancies, estimated at 10 per cent, have no access to maternal health services or to trained traditional birth attendants (TBAs). Long distances to health facilities and strong social traditions prevent women from seeking medical attention.

10. Another major cause of maternal mortality is the early age of marriage and early child-bearing. In Yemen, approximately 19 per cent of girls are married before the age of 20. Unregulated and unwanted pregnancies also increase the risk. Contraception use is below 5 per cent, but surveys suggest that the demand for contraceptives far outweighs the supply. Access to family planning services would reduce maternal mortality and have a positive impact on child survival.

11. The low level of development of the health services and the lack of trained health workers are major factors contributing to the poor health standards in the country. While there are almost 30,000 villages in Yemen, there are only 392 health centres and 1,200 primary health care (PHC) facilities. Recent studies confirm that national PHC coverage in 1991 was barely 40 per cent. Due to shortages of female health workers, only 25 per cent of health facilities offer maternal and child health (MCH) and family planning services. As the number of trained TBAs is estimated at 800, most deliveries are conducted in villages by untrained persons. Most villages are located in inaccessible areas and many rural families rely on accessible forms of traditional medicine rather than travel long distances to the nearest government health centre.

12. The number of medical doctors employed in the country is 2,573, 30 per cent of whom are expatriates. The majority of specialized health manpower is in urban centres and in the most developed governorates. Available data indicate that 50 per cent of specialized health workers and 48 per cent of doctors are employed in Sana'a City and Aden Governorate, serving 20 per cent of the total population.

13. The provision of health and other services to communities in Yemen is severely hampered by high centralization of administration and verticality of programmes. This leaves only a minor role for administrators at the district and service delivery level, resulting in poor replenishment of stocks and lower quality of services. However, unification of the north and south has initiated a process of decentralization of the health system administration and is expected to improve the situation.

14. Yemen suffers from serious shortages in its water supply. The high population growth rate, rapid urbanization and new irrigation projects upset the established balance between supply and demand. With safe water accessible to only 56 per cent of urban dwellers and 30 per cent of rural communities, groundwater reserves are in danger of being depleted. Rural water sources are not protected from contamination. Such practices as communal handwashing in a single container and the use of a single towel by several persons are common in rural areas.

15. Remarkable progress has been achieved since attaining independence in the late 1960s. The combined education system of unified Yemen now offers access to primary education for about 90 per cent of communities. City schools are large and well-designed. Rural schools, although sometimes barely adequate, are built mostly by the communities themselves.

16. However, the presence of a school in a village does not guarantee high attendance. Only 6 out of 10 children attend primary school, and of these, only two are girls. About 92 per cent of six-year-old boys start school, while the corresponding figure for girls is 56 per cent; and since girls drop out of school at a faster rate than boys, the absolute and relative numbers of illiterate Yemeni women are rising. The lack of female teachers and a critical shortage of classroom space are the major constraints to girls' education as the presence of female staff and the proximity of schools largely determine the level of school enrolment of girls in rural areas. While 80 per cent of Yemenis live in the countryside, over one half the total enrolment in general education is in towns. The quantitative expansion of the education system has lowered overall quality owing to insufficient funds for schools, classrooms, qualified teachers, furniture, books and teaching materials.

17. Traditionally, the system depended heavily on the employment of expatriate teachers funded by neighbouring countries. As a consequence of the Gulf conflict, however, this support was withdrawn in 1991 and the Government had no option but to draft 25,000 secondary school graduates into the primary school teaching force; of these, fewer than 200 were women. At present, therefore, the teaching force in rural areas, where the majority of the population live, comprises mainly unqualified, untrained and inexperienced young men. The difficulty in unifying the education systems of the two former republics, which

differed widely, has remained a problem. One major change has been the adoption of a country-wide, nine-year cycle of basic education, followed by three years of secondary education.

18. Non-formal education and literacy programmes were extensive and successful in the former People's Democratic Republic of Yemen, but less so in the Yemen Arab Republic, where women comprised only 20 per cent of students. Non-formal education and literacy programmes are now expected to expand considerably following the establishment of the Literacy and Adult Education Organization.

PROGRAMME COOPERATION, 1987-1992

19. UNICEF cooperation in Yemen during the 1980s focused on child survival and development (CSD). Assistance was directed towards reducing infant and child mortality caused by vaccine-preventable diseases, diarrhoea and dehydration and malnutrition.

Health

20. Efforts to increase service accessibility, particularly at the peripheral level, continued as part of the expansion of the PHC network throughout the country. UNICEF and the United Nations Capital Development Fund (UNCDF) jointly supported the construction and equipping of 141 PHC units in 8 northern governorates. Ten PHC units in Shabwa Governorate in the south were constructed and equipped on a cost-sharing basis. Despite many delays in implementation, this large project was completed successfully in 1991.

21. Increased attention was directed towards accelerating and expanding national immunization services in Yemen. As part of this process, UNICEF programme assistance in the People's Democratic Republic of Yemen and the Yemen Arab Republic was directed towards achieving the goal of UCI by 1990. Although part of an overall child survival strategy, immunization dominated the country programmes during the latter years of the 1980s.

22. In 1987, both countries had one of the lowest immunization coverage rates in the world. Yet, by 1990 both had achieved UCI for all antigens except measles. The strategy adopted in the north was an acceleration at the governorate level, with commitment from leadership, while the south used national campaigns with strong social mobilization components (the use of radio and television and the involvement of local leaders in promoting immunization). The achievements were tempered, however, by the underdeveloped state of health services, unavailability of resources, low level of training among health workers and the lack of awareness of the population regarding the benefits of immunization. The sustainability of immunization was also affected by management problems caused by the merger of the two national expanded programmes on immunization (EPI).

23. Since 1987, UNICEF has assisted national efforts to reduce the high levels of child mortality and morbidity associated with diarrhoea and dehydration. The main strategies adopted were promotion of ORT, increased availability of ORS, improved case management through training and social mobilization. In 1989, UNICEF began supporting local production of ORS in the Yemen Drug Company in

Sana'a. Since the start of local production, over 4 million packets of ORS have been distributed through health services and commercial channels.

24. Improving national capacity has always been a key strategy in UNICEF health projects in Yemen. During the past programme period hundreds of health workers and PHC workers were trained through pre-service and in-service training courses.

25. The Department of Health Education of the Ministry of Health has been assisted in producing high-quality television and radio programmes in the fields of health and nutrition. Staff have been trained in all aspects of video production and editing for television.

Water supply and sanitation

26. UNICEF has been closely associated with the development of community water supply systems in Yemen for many years. In 1990, a joint UNICEF/UNCDF project to construct 48 community water supply projects for the benefit of a population of 180,000 in 8 governorates of the north was completed. A similar community-based water supply and sanitation project has been implemented in the southern governorates with the support of the Danish International Development Agency (DANIDA). By the end of 1991, 114 small-scale community water supply systems had been constructed benefiting approximately 100,000 persons.

Education

27. UNICEF advocacy has focused attention on the magnitude and severity of the problems of the education sector, particularly in relation to girls' education. With UNICEF support, two important studies of girls' education and one of multi-grade teaching were conducted. Girls from rural areas have been encouraged to attend teacher-training courses. UNICEF has provided kits of teaching and learning materials for 300 primary schools.

28. In the non-formal education sector, 24 episodes of a television programme for literacy training were produced with UNICEF technical assistance and support in the form of reimbursable procurement of production equipment. UNICEF cooperation with the Yemeni Women's Union has supported female education, skills development and income-generating projects. Support was provided in cooperation with the British Organization for Community Development for training literacy trainers, and UNICEF funded a national workshop to set guidelines for the content of a proposed literacy and non-formal education programme.

29. Over the three years prior to unification, UNICEF assistance helped to establish six multi-purpose mass education centres, trained more than 6,000 literacy teachers and provided 15 educational booklets based on Facts for Life as reading material for those who had just learned to read.

Social mobilization and advocacy

30. Advocacy efforts have been increasingly targeted to high-level government officials, parliamentarians, opinion leaders and non-governmental organizations (NGOs), using the opportunities presented by the Convention on the Rights of the Child, the World Conference on Education for All and the World Summit for

Children. These efforts have resulted in the ratification of the Convention on the Rights of the Child in 1990 and adoption of World Summit goals in the 1991 National Population Policy. UNICEF was featured in international television programmes highlighting the achievements of UCI, the challenges facing basic education and the effects of the Gulf crisis on the economy and on social services.

31. Programme communication has been an integral part of UNICEF programming since 1989 and was a major factor in raising immunization coverage and ORS usage substantially. UNICEF cooperation has resulted in a significant increase in child survival-related television and radio broadcasting, press coverage and production of printed communication and training materials. In coordination with other donors, UNICEF has contributed to increasing significantly national capacity for planning, developing and implementing communication strategies and projects.

32. Religious leaders, teachers, youth groups, scouts and girl guides, women's organizations, community leaders and NGOs are the building blocks of social mobilization in Yemen. The strategy has been to enlist groups and other "channels" for community mobilization by providing training in child health and survival. Cutting across sectoral lines, the strategy promotes cooperation and draws on the support of the various government ministries, the Environment Protection Council, other official bodies and many NGOs. Long-term sustainability of this approach is assured, as the strategy is managed and implemented by the Government.

Emergency operations

33. In addition to regular programme activities, UNICEF has provided assistance in support of various emergency operations in Yemen since 1987. The return of 800,000 Yemeni workers from neighbouring countries as a result of the Gulf crisis had overloaded the capacity of local relief services and placed an enormous burden on the Government. UNICEF provided a large quantity of drugs and basic medical supplies during the height of the crisis.

34. In mid-1991, UNICEF emergency assistance was provided for cholera control operations in the south of the country. UNICEF air-freighted a consignment of medical supplies into the country. As the outbreak spread to other areas, a national plan of action was formulated to control and restrict the spread of the disease. UNICEF provided reimbursable procurement services to the Government for a large consignment of drugs and medical supplies and supported the cost of air-freighting the consignment to Yemen.

RECOMMENDED PROGRAMME COOPERATION, 1994-1998

Recommended general resources: $12,500,000
Supplementary funding: $12,000,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	4 080	4 205	8 285
Basic education	2 180	1 790	3 970
Communication and social mobilization	2 340	660	3 000
Area-specific programme	3 070	4 715	7 785
Monitoring, planning and advocacy for children	830	630	1 460
Total	12 500	12 000	24 500

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme preparation

35. Prior to the unification of Yemen, the Executive Board approved programmes for two cycles: 1987-1991 for the Yemen Arab Republic, and 1990-1995 for the People's Democratic Republic of Yemen. With unification, it was decided to utilize the balance of funds available under these programmes for the implementation of annual plans of action through 1993. This measure also allowed a reasonable transition period for the reorganization of government structures and facilitated the preparation of a new, unified country programme.

36. The country programme was prepared in collaboration with the Ministry of Planning and Development and other partners during a 14-month period in 1991-1992. A comprehensive situation analysis of women and children was also prepared. In December 1991 a strategy meeting was held for senior officials of the Government, United Nations agencies, donors, NGOs and UNICEF to review past and future UNICEF assistance. The recommendations of the meeting set the direction and strategy for the new programme. A subsequent preview meeting was held in Sana'a in May 1992 to examine and endorse the programme structure and content.

National goals for women and children

37. The unified Government acknowledges the fact that children constitute a large and vulnerable section of the population with special needs. In order to address their needs, the Government has committed itself, by endorsing various international conventions and agreements, to assign priority attention to children's issues. This commitment has been underscored by the acceptance of the principle of a "first call for children". Within the framework of the World Summit for Children Declaration, the Government has prepared a comprehensive national population strategy which embodies goals and objectives for women and children.

National population strategy

38. Immediately following the signing of the World Summit for Children Declaration, the Government organized the first National Population Conference at which senior government officials, elected members of the Peoples' Congress and representatives of various national and international organizations assessed the very high rates of infant, child and maternal mortality and the country's alarming fertility rate. The Conference adopted 14 national goals and endorsed a comprehensive national population strategy and national programme of action (NPA) to the year 2000.

39. Although the national population strategy was developed to address the country's rapid population growth, it also presents a comprehensive framework for human development in the country for the next decade. The 14 national goals endorsed at the Conference reflect the priorities set at the World Summit for Children. The NPA represents a broad-based strategy which, if fully implemented, will have a significant impact on the well-being of children and women in Yemen during the next decade.

Programme goals and objectives

40. The proposed programme of cooperation aims to support the country to achieve the following goals and objectives within the framework of the national population strategy: (a) reduction of IMR by 36 per cent, from 110 to below 70 per 1,000 live births; (b) reduction of U5MR by 30 per cent, from 180 to below 125 per 1,000 live births; (c) reduction of MMR by 25 per cent; (d) doubling of the enrolment of girls in primary school; and (e) increasing parental knowledge of practical actions that can be taken at household and community levels to improve CSD.

Programme strategy

41. The overall programme strategy is based on the analysis of the situation of women and children and on past programme experience. Because of the very high child mortality rate, improving child survival nationwide will continue to be the primary aim of the programme.

42. Many of the problems faced by women in Yemen stem from the neglect of education, nutrition and health needs of the young girl. The girl child is particularly vulnerable and is not given the opportunity to grow and develop to her full potential. Girl children have a lower status and enjoy fewer rights,

opportunities and benefits than boys, both in the family and in the community. Lack of schooling, the burden of domestic work, early marriage and too many closely spaced pregnancies adversely affect the health and well-being of the young mother. The UNICEF programme will give special attention to reducing the glaring gender disparities that exist within the society, community and home.

43. The country programme will emphasize building national capacity and enhancing self-reliance in the development and implementation of child survival interventions. Support will be provided to strengthen the organizational capacity of ministries and departments involved in social services; to train national staff involved in the planning and delivery of child survival programmes; and to improve skills in the fields of logistics, accounting and finance. The country programme will, to the greatest extent possible, involve local institutions and universities in situation analyses and planning and evaluation of programme interventions at the national and governorate levels.

44. Administrative and financial systems have long been overly centralized, restricting programme development and implementation at the local level. With the unification of Yemen and the concentration of national administration in Sana'a, the situation has been exacerbated, further slowing the process of development. Acknowledging this, the Government has begun to decentralize certain functions to the governorate level. In harmony with this policy, the country programme will provide direct support for local-level planning and implementation of social services and with new approaches for accelerated implementation in certain specified areas of the country. This area-specific programme approach will be based on a detailed assessment of the situation and problems of children at the local level. Working with governorate officials and local communities, appropriate support will be provided to improve the efficiency and effectiveness of services for children and women.

Health and nutrition

45. The country programme consists of six national projects to improve MCH: immunization; control of diarrhoeal diseases (CDD); control of ARI; safe motherhood; nutrition and child care; and strengthening PHC service delivery.

46. The objectives of the immunization project are to: reduce the incidence of poliomyelitis by 50 per cent; reduce measles-related U5MR from 12 to 5 per cent; and eliminate neonatal tetanus by 1995. UNICEF support aims to increase and sustain immunization coverage. To achieve this, more attention will be given to developing the capacity of governorate officials to plan, monitor and implement immunization services. While strengthening the regular services, special emphasis will be given to organizing outreach services. UNICEF will continue to provide vaccines and other vaccination supplies. However, the Ministry of Public Health is committed to providing resources to procure vaccines through the Vaccine Independence Initiative. To achieve the elimination of neonatal tetanus by 1995, present tetanus toxoid coverage levels among pregnant women will be increased, and girls in schools and women of child-bearing age will be immunized. This new approach will be backed by extensive social mobilization.

47. The CDD project aims to reduce diarrhoea-associated U5MR by 30 per cent and to reduce the incidence of diarrhoea among children under five years of age by 10 per cent. UNICEF will support the development and implementation of a

comprehensive CDD policy. This policy will comprise oral rehydration and continued feeding at home, proper case management and prevention of diarrhoea, using all existing channels of communication. The training component will cater to mothers, volunteers from the community and health workers, particularly to service ORT corners in health delivery units. UNICEF will continue to support the local production and distribution of ORS and provide raw and packaging material on a reimbursable basis beginning in 1996.

48. The objectives in the control of ARI are to reduce ARI-associated U5MR by 25 per cent and annual ARI episodes per child from five to fewer than three. UNICEF will support the development and implementation of a national policy. In addition, UNICEF will support training in case management and the development of information, education and communication materials for health providers at the primary level, including mothers, on prevention, detection and management of respiratory infections. UNICEF will supply drugs for a designated number of first-level health facilities and assist the Ministry of Health and NGOs in the provision of similar supplies to other health facilities, through identification of funding sources and procurement on a reimbursable basis.

49. The safe motherhood project aims to: increase to 60 per cent the number of pregnant women receiving antenatal care in health facilities; increase from 30 to 80 per cent the proportion of families with knowledge of birth spacing; increase to 40 per cent the number of deliveries assisted by a trained attendant; and decrease by 50 per cent the prevalence of anaemia in pregnant women. These objectives will be achieved through the training of traditional midwives in rural areas, increased emphasis on safe motherhood in the training courses of all health workers and the general improvement of maternal health services in health centres. Drugs and medical equipment will be provided to rural health clinics and hospitals to improve obstetric health. Working in close coordination with the United Nations Population Fund (UNFPA) and local NGOs supplying contraceptives, UNICEF will provide information and communication support for the promotion of birth spacing. With the goal of reducing the total fertility rates to 6, the programme will support the training of health providers and physicians to communicate family planning information and to advise couples and mothers before, during and after pregnancy on the benefits of family planning. Flipcharts, audio cassettes and demonstration kits will be developed to assist health providers in communicating with potential clients.

50. Facts for Life messages relating to safe motherhood and family planning will be disseminated through radio and television programmes and through the print media. Radio programmes will be produced in regional centres to ensure local relevance. Religious and community leaders will be provided with a range of support materials, including posters and booklets.

51. In recognition of the high levels of child malnutrition in the country, the nutrition and child care project will give special attention to: increasing from 5 to 30 per cent the prevalence of exclusive breast-feeding up to 4 to 6 months of age; reducing the prevalence of iodine deficiency disorders and rickets among children under five years of age by 25 and 50 per cent, respectively; and improving the growth monitoring and promotion of young children. Communication strategies will be developed to highlight the positive benefits of breast-feeding on the health and growth of the infant. Special emphasis will be given to promoting breast-feeding in hospitals and maternity

units through the "baby-friendly" hospital initiative. Emphasis will be given to improving nutrition at the household level; appropriate strategies of control will be developed using vitamin and iodine supplements. Cooperation with immunization activities will be reinforced. Health workers will be trained to monitor the growth of infants and young children through appropriate means.

52. The objectives of the project for strengthening PHC service delivery are to assist in the formulation of a new health care policy and in developing and applying appropriate community financing schemes. To address weaknesses impeding the effectiveness and quality of services, support will be provided to strengthen management capacity in the central public health department of the Ministry of Health and in governorate health offices. Special attention will be given to supporting these critical requirements through training of PHC managers, preparation of national PHC guidelines, adoption of appropriate essential drugs lists, development of monitoring and management systems, organization of supervision schedules and improvement of standard training courses for PHC workers. Cost-recovery schemes based on the Bamako Initiative will be investigated as a means of providing a regular and sustainable supply of essential drugs to PHC units and health centres.

Basic education

53. The programme will comprise the following projects: primary education; women's literacy; and communication for learning. The overall strategy is to assist in overcoming the major factors impeding the education of girls and to create positive changes in individual, local and national attitudes towards girls' education and the status of women in society and national development. The activities will include training female teachers; supplying textbooks, primary school kits and two-class teaching materials; improving the learning environment of schools; introducing alternative shifts for girls; and providing female supervisors. The country's communication resources will focus on promoting girls' education and changing traditional attitudes. The outreach and effectiveness of the mass media will also be used as a tool to disseminate skills for life, with special emphasis on reaching out-of-school girls. Female literacy teachers will be trained and materials for newly literate persons will be produced. Small-scale, innovative, area-specific projects to make schools more attractive to communities will be established as a first step towards wider replication. A joint working structure will be established with the Government to streamline cooperation, particularly at the local level.

Communication and social mobilization

54. This programme consists of three projects: development of communication capacity; fostering environmental awareness; and circulating information among women and women's groups. It is designed to strengthen national and local capacities to plan and implement communication and mobilization strategies.

55. The first project, aimed at developing alternative channels for interpersonal communication, will mobilize resources for improving child survival, protection and development, using Facts for Life and other information. Radio and television programming will be improved and key partners will be identified and mobilized to advance programme goals across sectors.

56. The second project has an objective of making 50 per cent of families aware of environmental issues. It will study community perceptions of environmental problems and, by analysing them in relation to the health and well-being of the family and child, develop strategies for primary environmental care at the community level. By involving scouts and guides, children from the communities themselves will be encouraged to play a catalytic role. With the help of key partners, information, education and communication materials will be prepared and made available to schools, training institutes, universities, NGOs and, through radio, television and the press, to the public.

57. The third project aims to create a favourable environment for the growth and development of girls and women and for improving the status of women. It will complement and support the "communication for learning" project by helping women's groups to develop and implement appropriate communication strategies and produce materials and training packages. Studies on gender roles and biases will be conducted and women's groups and local informal women's associations will be identified as entry points for interpersonal communication of skills for life information and curricula.

Area-specific programme

58. Despite the impressive gains that have been achieved in social development in the country, considerable disparities continue to exist between and within governorates. In the previous programme cycle progress had been restricted by a slow and over-centralized decision-making process. The new country programme will assist the Government in its stated policy of decentralizing many of the programme planning and implementation functions directly to governorate authorities.

59. UNICEF will support efforts in four governorates to experiment with approaches to accelerate CSD. In a phased manner the programme will support community-based interventions in the fields of improved management and delivery of health care, basic education with a focus on the girl child and community water supply and sanitation. Working directly with local officials and communities, project managers will develop projects after conducting a detailed analysis of the local situation. These approaches for improving the situation of children will be tested and successful approaches will be shared and replicated in other governorates.

60. A major component of the programme will be the development of a community water supply and sanitation project in two governorates in the south of the country. This project will extend an existing DANIDA-supported project to construct an additional 100 water supply schemes in selected villages.

Monitoring, planning and advocacy for children

61. To assist the Government in monitoring progress towards achieving its national goals, UNICEF will support efforts to collect, analyse and publish social development data. As part of a monitoring, planning and advocacy programme, UNICEF will support two projects. The monitoring and planning project will support studies of child-related issues, the training of staff involved in collecting and interpreting social statistics and the effective presentation of data to policy makers and the public. The advocacy for children

project will focus on making children's concerns part of the public consciousness and of the political and policy-making arenas. By motivating local organizations and groups to speak out on child issues, a coalition of informed advocates for children will be established within five years. Using this strategy, the provision and expansion of services for children will be accelerated by public demand.

62. Monitoring progress and evaluating achievements versus objectives will be an important component of all programme interventions. Monitoring and evaluation will take place through routine reporting systems, feedback from outreach workers, regular limited-scale rapid appraisals and occasional national surveys. It will be based on a list of major indicators for each programme area developed by UNICEF and its counterparts. Annual programme reviews will be conducted during the last quarter of each calendar year under the coordination of the Ministry of Planning and Development and with the participation, as and where appropriate, of United Nations agencies and other concerned parties. These reviews will form the basis of annual formulation of, and resource allocation for, the project plans of action. Prior to the programme mid-term review scheduled for mid-1996, three major evaluations will be undertaken in 1995: one combining disaggregated assessments of infant mortality, EPI, CDD and ARI rates and efficacy of health service delivery; one on learning achievement in schools; and one on progress in acquisition by the family of essential knowledge for living, assessed against specific indicators. In addition, evaluations will be made of area-based interventions to gauge results and determine if the projects will be widely replicated. Experience in programme management and project implementation will also be evaluated as part of the mid-term review. The situation analysis of children and women will be updated regularly and will provide a further basis for the mid-term and annual reviews of the country programme.

Cooperation with other agencies

63. Yemen was among those countries selected for cooperation with the Joint Consultative Group on Policy. Close collaboration between the United Nations Development Programme (UNDP) and UNICEF culminated in a round-table conference on Yemen in Geneva in mid-1992. Preparations for the national population policy put in practice the joint efforts of United Nations agencies. The UNICEF country programme has been developed in close cooperation with other United Nations agencies working in Yemen, including UNDP, WHO, UNFPA, the Food and Agriculture Organization of the United Nations and the World Food Programme. Consultations have been held with the World Bank, particularly in the fields of health and girls' basic education. Various bilateral agencies and at least 10 international and national NGOs will be associated with programme implementation.

Programme management

64. A detailed analysis of the human and financial resources required to implement the programme was conducted within the context of the country programme management plan. The new programme will be implemented through the

UNICEF country office in Sana'a and the project sub-office in Aden. Programme management will be based on existing staffing structures in the two offices. However, with social mobilization and communication as essential components of all programmes, the communication section will be strengthened in 1994 with the addition of one national Professional officer.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Yemen	(1991 and earlier years)		UNICEF country classification
Under-five mortality rate	182	(1991)	Very high U5MR
Infant mortality rate	110	(1991)	High IMR
GNP per capita	$ 540	(1991)	Lower-middle GNP
Total population	12.1 Million	(1991)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1991
Births	(Thousands)	338	442	587	600
Infant deaths (under 1)	(Thousands)	60	63	66	66
Under-five deaths	(Thousands)	99	104	110	110
Under-five mortality rate (per 1,000 live births)		293	236	187	182
Infant mortality rate (under 1) (per 1,000 live births)		177	142	113	110

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1979-1983/1991-1992)	Moderate & severe	53	30
	Severe	..	4
Babies with low birth weight (%, 1990)		..	19
% of primary school children reaching final grade, 1988)		..	53

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1979-1985)	74 /66/ 34	.. / .. / ..
Prevalence of wasting (%, 1979-1983/1991-1992)	15	17
Prevalence of stunting (%, 1991-1992)	..	8
Daily per capita calorie supply (% of requirements, 1984-1986)	..	92
Food production per capita index (Index 1979-1980=100, 1991)	..	79
Household expenditure (% of total income) All food/cereals		.. / ..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987-1988)			7
Access to health services	Total	..	38
(% of population, 1985)	Urban/rural	.. / ..	.. / ..
Access to safe water	Total	..	38
(% of population, 1990)	Urban/rural	.. / ..	56 / 30
Access to adequate sanitation	Total	..	51
(% of population, 1990)	Urban/rural	.. / ..	37 / 64
Births attended by trained personnel (%, 1988)		..	12
Maternal mortality rate (per 100,000 live births)		..	..

Immunization		1981	1985	1989	1991
One-year-olds (%) immunized against:	Tuberculosis	14	..	71	..
	DPT	21	..	53	..
	Polio	21	..	53	..
	Measles	33	..	45	..
Pregnant women (%) immunized against:	Tetanus	..	..	8	..

TABLE 1 (continued)

Yemen

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1988)	Total	55 / ..	87 / ..
	Male	85 / ..	132 / ..
	Female	24 / ..	39 / ..
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	11 / ..	25 / ..
	Male	16 / ..	42 / ..
	Female	6 / ..	7 / ..
Adult literacy rate, 15 years & older (%, 1970/1991)	Total	9	33*
	Male/female	14 / 3	54*/ 15*
Radio/television sets (per 1,000 population, 1980/1989)		28 / 5	59 / 27

DEMOGRAPHIC INDICATORS		1970	1980	1990	1991	2000**
Total population	(Thousands)	6332	8219	11684	12104	16424
Population aged 0-15 years	(Thousands)	2909	4378	6077	6297	8316
Population aged 0-4 years	(Thousands)	1159	1658	2390	2453	3045
Urban population (% of total)		13	20	29	30	38
Life expectancy at birth (years)	Total	41	46	51	52	57
	Male	41	46	51	52	56
	Female	42	47	52	52	57
Total fertility rate		7.8	7.7	7.4	7.3	6.4
Crude birth rate (per 1,000 population)		53	53	50	49	44
Crude death rate (per 1,000 population)		23	19	15	15	11

		About 1980	Most recent
Contraceptive prevalence rate (%)		..	..
Population annual growth rate (%, 1965-1980/1980-1991)	Total	2.3	3.5
	Urban	6.4	7.1

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%)		..	..
Inflation rate (%)		..	..
Population in absolute poverty (%)	Urban/rural	.. / ..	.. / ..
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure (% of total expenditure)	Health/education	.. / ..	.. / ..
	Defence	..	..
Household expenditure (% of total income)	Health/education	.. / ..	.. / ..
Official development assistance: (1980/1991)	$US millions	572	540
	As % of GNP	13	8
Debt service (% of goods and services exports, 1990)		..	17 a/

a/ Indicates data that differ from the standard definition, or refer to only part of a country.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1990-1993 a/

COUNTRY: YEMEN
LATEST BOARD APPROVAL: 1990
GENERAL RESOURCES: $9,180,000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	3969	587	435		1306	258	879	31	6589	7225	876	2003	7465	9228
Water supply and sanitation		1199		1	167	230	24	88	191		1518	4800	1709	4800
Education	506	60	90	15	203		203	2	1002	1000	77	818	1079	1818
Social mobilization and advocacy	22						1	72	23		72		95	
Planning and social statistics	115		27		3		105		250	255			250	
Emergency	196	70		10		8		49	196	196	137		333	
GRAND TOTAL	4808	1916	552	26	1679	496	1212	242	8251	8676 b/	2680	7621	10931	15846

GR = General resources.
FSF = Funded supplementary funding.
SF = Supplementary funding, funded and unfunded.
a/ Actual expenditure includes expenditure recorded as of 17 December 1992.
b/ Including $196,000 from the Emergency Reserve Fund.

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TABLE 3. PLANNED EXPENDITURE, 1994 – 1998

(In thousands of United States dollars)

Country: YEMEN **Period covered: 1994 – 1998**	**Funding status**	**1994**	**1995**	**1996**	**1997**	**1998**	**Total**
Health and nutrition	GR	945	945	695	750	745	4080
	NSF	1047	995	810	719	634	4205
Basic education	GR	545	315	485	400	435	2180
	NSF	453	294	366	301	376	1790
Communication and social mobilization	GR	420	450	470	490	510	2340
	NSF	90	110	130	150	180	660
Monitoring, planning and advocacy	GR	110	200	200	160	160	830
	NSF	90	120	120	160	140	630
Area-specific CSD programme	GR	480	590	650	700	650	3070
	NSF	720	881	974	1070	1070	4715
TOTAL	GR	2500	2500	2500	2500	2500	12500
	NSF	2400	2400	2400	2400	2400	12000
GRAND TOTAL		4900	4900	4900	4900	4900	24500

GR = General resources.
NSF = New supplementary funding.

TABLE 4. LINKAGE OF PROGRAMME BUDGET AND STAFFING/STAFF COSTS

YEMEN

PROGRAMME SECTION/AREAS AND FUNDING SOURCES	PROGRAMME BUDGET 1994–1998 (In thousands of US dollars)				POSTS a/ and b/ EXISTING POSTS						SUBTOTAL			TOTAL POSTS	STAFF COSTS c/ (In thousands of US dollars)		
	GR	FSF	NSF	TOTAL	D2/L7	D1/L6	P/L5	P/L4	P/L3	P/L2	IP	NP	GS		IP	LOCAL	TOTAL
GENERAL RESOURCES																	
Health and nutrition	4080			4080				1		1	2		1	3	1274	100	1374
Basic education	2180			2180								1	1	2		324	324
Communication and social mobilization	2340			2340				1			1	1	2	4	637	424	1061
Monitoring, planning and advocacy	830			830													
Area-specific CSD programme	3070			3070				1			1	1	2	4	637	424	1061
Programme support d/												1	5	6		770	770
TOTAL GR	12500			12500				3		1	4	4	11	19	2548	1992	4540
SUPPLEMENTARY FUNDING																	
Health and nutrition			4205	4205													
Basic education			1790	1790													
Communication and social mobilization			660	660													
Monitoring, planning and advocacy			630	630													
Area-specific CSD programme			4715	4715													
TOTAL SF			12000	12000													
TOTAL GR & SF				24500				3		1	4	4	11	19	2548	1992	4540
ADM. AND PROGRAMME SUPPORT BUDGET (Proposed 1994–1995)	Operating costs			397													
	Staffing b/						1	1	1		3	1	10	14	797	681	1478
GRAND TOTAL (GR + SF + ADM)							1	4	1	1	7	5	21	33			
	Number of posts and staff costs:																
	– At the beginning of previous programme (1990)										13	5	24	42	N/A	N/A	N/A
	– At the beginning of proposed programme (1994)										7	5	21	33	N/A	N/A	N/A
	– At the end of proposed programme (1998) (Indicative only)														N/A	N/A	N/A

a/ Each post, regardless of its funding source, supports the country programme as a whole.

b/ The posts are effective 1 January 1994.

c/ Project posts are funded for five years and core posts are funded for two years.

d/ Spread over various sectors.

Abbreviations: GR = general resources; FSF = funded supplementary funding; NSF = new supplementary funding; SF = supplementary funding; IP = International Professional; NP = National Professional; GS = General Service; ADM = administrative.